

McLaren Print System Order

Order No: 73616 Reprint Previous Order No: 6293
Order Date: 2022-11-14
User: STEPHANIE BENDER
Phone: 12314877441

Ship Location: Gaylord Family Practice
1320 M-32 East
Gaylord, MI 49735

Forms

Quantity: 500
Paragon Dept No: 50684
Dept Name: Gaylord Family Practice
Company Number: 810

Order Total Price: 0.00

Item Number: 17418
Item Description: Authorization to Release Information (this is a corporate wide form c/o Medical Records)
Revision Date: 4/28/2015
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLAREN HEALTHCARE
Authorization to Release Information

Patient Name _____ Ethnicity _____ Medical Record Number _____
Address _____
Phone Number _____ Identification Number _____

I authorize _____ to release to _____
(Name) (Name)
(Address) (Address)
(City, State, Zip) (City, State, Zip)
(Telephone/Fax) (Telephone/Fax)
(Email Address) (Email Address)

Specific type of information to be disclosed: _____ **Date(s) of Service:** _____
 History and Physical Operative Report Physician's Notes
 Consultation Reports Therapy Notes Discharge Summary
 Laboratory Results Billing Records Home Care Records
 Diagnostic Imaging (e.g., X-Ray reports from (date) _____
 Diagnostic Imaging (e.g., X-Ray reports from (date) _____
 Other _____

Sensitive information to be disclosed: _____ **Date(s) of Service:** _____
 Behavioral and Mental Health Service Information (including Psychotherapy Notes)
 Human Immunodeficiency Virus (HIV) and substance use disorder
 Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus
 HIV Infection, Acquired Immune Deficiency Syndrome or AIDS-Related Complex

Consent to release **Entire Medical Record**, for dates of service listed, including all information noted above.
Date(s) of Service: _____
_____ Date

Please continue to the other side of this form for Acknowledgements and signatures.